OurHealthEquity.org

Testimony Opposing HB2385 – Senate Committee on Health Care
May 6, 2025

As the advisor and director of Our Health Equity, I write to you in opposition to HB2385. Our Health Equity is a nonprofit organization committed to improving access to medicine, reforming the charity healthcare system, and ensuring that each person has access to proper nutrition and clean drinking water.

On April 24, U.S. Senator Bill Cassidy, M.D., chair of the Senate Health, Education, Labor, and Pensions (HELP) Committee, released a report on the federal 340B Drug Pricing Program, detailing findings from his years' long investigation into how covered entities (certain health care facilities or programs that serve low-income patients, as designated in law) use and generate revenue from the program.

Congress created the 340B program in 1992 to allow covered entities to purchase outpatient drugs at a discounted rate "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." Drug manufacturers are required to provide these discounts as a condition of participation in the Medicaid Drug Rebate Program.

According to a press release issued by his office, as part of his investigation into the 340B Program, Senator Cassidy requested information from hospitals, Federally Qualified Health Centers (FQHCs), contract pharmacies, and drug manufacturers to better understand how revenue flows throughout the 340B Program and how covered entities use 340B revenue to benefit patients. He found that Bon Secours Mercy Health and Cleveland Clinic, both of which are covered entities, generated hundreds of millions of dollars in 340B revenue, but do not pass 340B discounts directly to their patients.

Shockingly, the two investigated hospitals saved hundreds of millions of dollars from 340B, and their executives stated that the 340B program was not designed to provide direct savings to patients. **Additionally, these hospitals report using 340B revenue on "capital improvement projects" and "community benefit programs," but do not account for what specific expenses 340B revenue goes towards. This cavalier and unaccountable approach to 340B funds is pervasive.**

Senator Cassidy's report also found that CVS Health and Walgreens charge covered entities a complex range of fees for using their pharmacy services to dispense 340B drugs to patients. They also charge additional administrative fees for Third Party Administrator (TPA) services. These fees, which generally increase each year, divert resources from the 340B program's intended purpose.

Clearly, the 340B program needs to be reformed—in a major way.

Oregon has an opportunity to improve health equity, but HB2385 does not address the areas that need it most. While the bill aims to protect 340B covered entities from exploitation and obstacles created by drug manufacturers, the true beneficiaries of this reform are not the underserved patients it is intended to help, but rather the covered entities themselves.

The 340B program was designed to help eligible safety-net providers generate funds to better serve low-income and uninsured patients. However, minimal oversight and transparency requirements allow for covered entities and contract pharmacies to make a profit without reinvesting in charity care in high-need communities.

HB2385 will expand the access these covered entities have to discount drugs, with nothing to ensure those discounts are passed down to patients.

Instead of expanding this failing system, Oregon should prioritize reforms that put patients over profits.

This means:

- Requiring 340B "covered entities" to provide detailed financial statements to the State Auditor, delineating the dollars received through the 340B program and where those dollars were spent.
- Clearly define what a 340B-eligible patient is in the State of Oregon—e.g., a patient at or below 200% of the federal poverty level.
- Require that covered entities funnel 340B dollars to eligible patients and demonstrate publicly that it happens and precisely how.

Without implementing these guidelines, 340B covered entities will continue to profit from the communities it is designed to serve, forcing patients to pay high prices for care while covered entities and contract pharmacies benefit from 340B discounts. There is a unique opportunity to reform the 340B program, but HB2385 focuses on increasing protection for covered entities instead of making meaningful changes for patients.

I urge you to pursue significant changes in the organization and oversight of the 340B program to ensure it serves high-need communities. It's time to rethink HB2385 and shift the focus to the best interest of Oregon's patients.

Thank you,

Laura Brod-Hameed, Advisor/Director

OurHealthEquity.org

(612) 437-8836

340B Case Study: Richmond Community Hospital

How is Bon Secours supporting the underserved patients that the program was designed to help at Richmond Community Hospital?

Let's take a look...

Richmond Community Hospital

Serves Richmond's largest Black population, lacks basic resources and reliable equipment. Despite these struggles, the nonprofit hospital, owned by Bon Secours, has the highest profit margins of any hospital in Virginia.

340B In Action

Richmond Community Hospital can purchase a cancer drug for $3,444 and bill insurance $25,425, generating a $22,000 profit per vial. The program clearly creates substantial revenue for the hospital, as intended. Yet, 340B hospitals such as Richmond Community Hospital are not expanding their resources to regions that need it most.

Join our campaign at

OurHealthEquity.org

[1]https://www.vhi.org/Bon%20Secours%20Richmond%20Community%20Hospital.html?tab=&?=h9880/
[2]https://storymaps.arcgis.com/stories/e51284979e494f228df0d46198aace40
[3]https://paddockpost.com/2024/10/03/executive-compensation-at-bon-secours-mercy-health-2022/
[4]https://bsmhealth.org/leadership/john-starcher/
[5]https://projects.propublica.org/nonprofits/organizations/540647482
https://www-nytimes-com.cdn.ampproject.org/c/s/www.nytimes.com/2022/09/24/health/how-a-hospital-chain-used-a-poor-neighborhood-to-turn-huge-profits.amp.html

How does the 340B program work?

The 340B program allows hospitals in underserved areas to buy discounted drugs and bill insurance at full price. The program was designed to help low-income patients afford their medicines and provide access to charity care. However, large hospital chains exploit lenient transparency and reporting rules by opening clinics in wealthier areas, treating insured patients, and linking them to underserved hospitals on paper.

$42,671,373

in net revenue in 2017 at Richmond Community Hospital after Bon Secours closed its ICU and key specialists left. This turned Community Hospital into a glorified emergency room.[1]

At least 4 cases of patients not receiving proper care due to a shuttered ICU at Richmond Community Hospital between 2017 and 2021.

2 resulted in death

1 resulted in life-long cardiac issues

1 resulted in an amputation

More Than Half

the households in the neighborhoods surrounding Richmond Community Hospital do not have a car, according to research[2] done by Virginia Commonwealth University. Public bus routes to Saint Mary's, where patients can receive specialized care, take more than an hour.

$4.75 million

The average annual amount spent on improvements to Richmond Community Hospital and the surrounding community from 2018-2022, according to Bon Secours.

$11,580,768[3]

2022 take-home pay of John M. Starcher Jr.[4], CEO of Bon Secours Mercy Health.

98.5%

of Richmond Community's revenue comes from program services, yet Dr. Lucas English, a former emergency department worker, claims Bon Secours was essentially laundering money from the poor hospital to its wealthier locations for profit. At the chain's St. Francis Medical Center, just 18 miles away, golf carts transport patients past marble fountains in a luxurious suburban setting.[5]